Alabama Department of Youth Services School District #210
Sick Leave Bank Participant
Catastrophic Sick Leave Transfer Authorization

Please Print

Donating Employee Information – To be completed by donating employee

1. Employee Name:
2. Social Security Number:
3. Employee Address:
4. Employee Telephone(s):
5. Employer:

Beneficiary Employee Information - To be completed by donating employee

6. Receiving Employee Name:
7. Social Security Number:
8. Beneficiary's Employer:

Days to be donated to Beneficiary (not to exceed 30 days per any employee)

To be completed by donating employee

9. Number of Days to be donated:

Certification of Donating Employee – To be completed by donating employee

10. I certify that I hereby donate the above noted number of my sick leave days to the beneficiary employee listed above. My employer has my permission to transfer the indicated number of sick leave days to the employer of the beneficiary for his or her use to a catastrophic illness/injury as defined by Act 93-753. *It is my understanding that my sick leave balance will be reduced by the specified number of days hereon and that the donated days will not be returned to me.*

Donating employee's signature:_____ Date: _____

Witness' signature: _____ Date: _____

Certification of Donating Employer – To be completed by donating employee

11. I hereby certify that the donating employee's information listed above is correct to the best of my knowledge.

Authorizing Signature: _____Date: _____

Title: _____

Receipt of Beneficiary Employer – To be completed by Beneficiary's employer

12. The above noted number of sick leave days have been credited to the sick leave account of the beneficiary employee. (Please give a copy of this from to the beneficiary employee.)

Authorizing Signature: _____ Date: _____

Title: _____